Rae A. Winters, OD
Developmental Optometry & Vision Therapy Department
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BINOCULAR VISION EVALUATION FAX REFERRAL FORM
Fax to: 317-458-1594

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Date

____
Referred By

____
Office Name

____
Office Address

____
Area Code Phone Fax

____
Patient's Name Age Date of Birth

____
Contact Information: Parent's Name

____
Address

____
City State Zip

____
Area Code Phone Best time to call

Preferred Location for Evaluation: ☐ **Greenwood** ☐ **Geist**

Reason(s) for Referral:

- ☐ Binocular Vision Disorder
- ☐ Accommodative Difficulties
- ☐ Strabismus/Amblyopia
- ☐ Visual Perceptual Problems
- ☐ Problems with Attention
- ☐ Other:______________
- ☐ Eyestrain/Headaches
- ☐ Diplopia
- ☐ Convergence Insufficiency / Excess
- ☐ Poor Handwriting
- ☐ Developmental Delays
- ☐ Post Trauma/Stroke Vision Evaluation
- ☐ Tracking/Oculomotor Dysfunction
- ☐ Loss of Place when Reading
- ☐ Trouble Copying from Board
- ☐ Difficulty seeing 3D/Stereo Vision

Results of Examination:

Refraction: ☐ Wet ☐ Dry

OD______________________________ VA OD________ Spec Rx OD______________________________

OS______________________________ VA OS________ Spec Rx OS______________________________
(if given)

☐ DFE performed – no ocular health abnormalities noted Other: ______________________________

Additional information: ______________________________

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ATTENTION PATIENT & REFERRING DOCTOR – PLEASE READ PARAGRAPH BELOW AND SIGN ON THE LINE:

I hereby grant permission for Dr. Winters and any other professional involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I also hereby give permission to have this information faxed to Dr. Winters so that her office can contact me (or my appointed representative) to schedule an evaluation.

____
Patient/Parent Signature Date Signature (Doctor) Date

A copy of all tests results and a report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.